

Must be received by the Benefits Department
within 31 days of the qualifying event. MS 1022

To go to the top of the form press TAB.

Press

Commercial Enrollment / Change Form**Employer:** Complete Section A**Employee:** Complete Sections B, C and D**Health Plan:** Complete Section E*Please print and thank you for providing this information*Insured and/or Administered by
Connecticut General Life Insurance Company LOVELACE HEALTH SYSTEMS

CIGNA

A	<input type="checkbox"/> OPEN ENROLL <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL <input type="checkbox"/> REINSTATE	EFFECTIVE DATE	EMPLOYER NAME	LOVELACE ACCOUNT NO. 2025640	GROUP / DIV. NO.	MEDICAL BEN. OPTION N/A	DATE OF HIRE
	TYPE OF CHANGE <input type="checkbox"/> Add Dependent(s) * <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Placement <input type="checkbox"/> Other _____ Date of Change: _____						
<input type="checkbox"/> Cancel Employee <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Other Insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Address Change							<input type="checkbox"/> Cancel Dependent(s) * <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Change in Student Status <input type="checkbox"/> Other _____ * List Names in Section B
<input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos.							<input type="checkbox"/> Family Security Benefit / Surviving Spouse <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____

R	EMPLOYEE NAME (Last) _____ (First) _____ (M.I.) _____			SOCIAL SECURITY NO. _____		HOME PHONE _____		WORK PHONE _____	
	ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____								
	I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS (Specify last name if different from yours) If enrolling more than 3 dependents, use a second form.			SOCIAL SECURITY NUMBER		DATE OF BIRTH		SEX	
	Last Name _____ First Name _____ M.I. _____					Mo Day Year		FULL TIME STUDENT? Yes No	
	EMPLOYEE							<input type="checkbox"/> M <input type="checkbox"/> F	
	SPOUSE							<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent * Relationship							<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent * Relationship							<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent * Relationship							<input type="checkbox"/> M <input type="checkbox"/> F		
							<input type="checkbox"/> M <input type="checkbox"/> F		
* DEPENDENTS - If totally disabled, attach proof of disability for eligibility review.									

C	OTHER HEALTH CARE COVERAGE:					Have you or your dependent(s) ever been covered by Lovelace Health Plan?				
	Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No				
	If yes, please provide the following:					If yes, Name of Person Covered _____				
	NAME OF PERSON COVERED SOCIAL SECURITY NO. EMPLOYER INSURANCE COMPANY NAME AND ADDRESS <div style="display: flex; justify-content: space-around;"> <div>MEDICARE Part A <input type="checkbox"/></div> <div>Part B <input type="checkbox"/></div> </div>					I.D. No. _____ Covered As: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent				

D	I have read the descriptive literature outlining the Lovelace Health Systems (LHS) medical plan and I hereby apply for participation in said Plan. I authorize my employer to deduct from my earnings the employee's contribution, if any, to the premium under the LHS Agreement (contract). I also authorize the health care provider from which I or my dependents receive health care services to disclose to LHS any information concerning me or my dependents contained in the records of the health care provider. I understand that membership may be automatically terminated if I have given any false information regarding myself or dependents on this application. I agree that all sums payable by other health plans (including Medicare, Medicaid, Champus and Workers Compensation) shall be payable to and retained by LHS. I agree for myself and my dependents to complete and submit to LHS such consents, releases, assignments and other documents requested by LHS to assure such payment.	
	SIGNATURE - The information provided above is true and correct to the best of my knowledge. I agree on behalf of myself and my covered dependents to the provisions on the reverse side of this form. SUBSCRIBER SIGNATURE _____ DATE _____	

E	LOVELACE HEALTHPLAN USE ONLY	
	MEMBER NUMBER <div style="text-align: right;">-01</div>	
	PLAN CODE	
	LMC ACCOUNT # GROUP #	

PROVISIONS

- I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

APPLICABLE TO HMO BENEFITS

- I authorize payment of any and all benefits payable under the policy to any licensed provider of care who treats me and/or my covered dependents.
- Lovelace Health Systems provides HMO coverage under agreements with your employer, and provides the HMO coverage under LOVELACE HEALTH ACCESS.
- I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.
- I authorize any Provider, Insurance Company, Employer or Organization to release any information on me or my dependents regarding medical, dental, mental health or substance abuse history, treatment or benefits payable, to the Plan Administrator, its authorized agent, the Lovelace Health Systems entity administering this Plan or my primary care physician for the purpose of determining benefits in connection with this Plan or for quality assessment purposes. This authorization for release of substance abuse history, treatment or benefits payable is subject to revocation at any time except to the extent that disclosure of such information has already been made to the Plan Administrator, its Authorized Agent, the Lovelace Health Systems entity administering this Plan or my primary care physician.
- I authorize payment of any and all benefits payable under the policy to the Participating Provider of the benefits who treats me and/or my covered dependents.
- I authorize that payment be made under Part B of Medicare to Lovelace Health Systems for medical and other services furnished me for which it pays or has paid, if applicable.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.
- I understand that membership may be automatically terminated if I have given any false information regarding myself or my dependents on this form.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I understand that it is necessary for the parties administering the plan in which I am enrolling to obtain and/or provide to others "Confidential Information," as defined below. Therefore:

1. I authorize any person or entity having Confidential Information to provide any such Confidential Information upon request to Lovelace, any Lovelace participating provider, or any other provider or entity performing a service for the purpose of eligibility determination under the plan, the administration of the plan, the performance of any Lovelace Program or operation, or assessing quality and accessibility of health care services and supplies.
2. I authorize Lovelace to disclose any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of Lovelace programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration.
3. I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I understand that it will remain in effect until I send a written notice revoking it to Lovelace or for such shorter period as required by law. Until revoked, this authorization may be relied upon by Lovelace and other parties.

"Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

"Lovelace" means Lovelace Health Systems, Inc. and/or any other CIGNA HealthCare entity involved in the administration of the plan.